Principles, Procedures and Protocols for Elder Abuse

February, 1992

InterMinistry Committee on Elder Abuse
and
Continuing Care Division
Ministry of Health and
Ministry Responsible for Seniors

93-01176

TABLE OF CONTENTS

Introduction 1

Principles 3

Definitions 5

Generic Protocol 7

Community Resources 9

Provincial Telephone Numbers 10

Conclusion 11

Appendix A: Intake Form i

Appendix B: Sample Protocols iii

Appendix C: Common Indicators of Abuse and Neglect xxiii

Appendix D: Financial Abuse Authority xxiv

Appendix E: Licensing Authorities xxvi

Appendix F: Resources xxvii

Appendix G: Bibliography xxviii

Appendix H: Resource List xxxi

INTRODUCTION

For years, elder abuse has been hidden by social and familial taboos and has only come to the attention of the public within the last decade. It can take the form of physical, psychological, financial, sexual or medication abuse, or violation of civil/human rights or neglect. Elder abuse, like other forms of family violence, cuts across race, class and religious lines and is usually perpetrated by someone who has control or influence over the older person. A national survey has estimated that 16,000 seniors in British Columbia are subject to some form of abuse or neglect.[1]

Elder Abuse is a multifaceted problem which involves health care, social and legal issues. Victims may require a wide variety and combination of remedies and responses. In British Columbia, the goal is a coordinated, interdisciplinary, community-based response to the problem. This approach means that each community will coordinate its own response to cases of elder abuse based on the resources available in the community.

When elderly persons living in their own homes are being abused or neglected, there is as yet no mandated response nor is there legislation that requires reporting or investigation of abuse. However, when it is suspected that elderly persons who are living in care facilities licensed by the Ministry of Health and Ministry Responsible for Seniors are being abused or neglected, legislation is in place which requires that all serious incidents and accidents be reported to the relevant licensing authority for investigation (see Appendix E).

This document is written for people who work with the elderly and is being distributed throughout British Columbia to provide an introduction to and guidelines for responding to elder abuse. It is generic in its approach and is based on the following assumptions: that there are many kinds of abuse; that many agencies may be called upon to respond to reported abuse cases; that different services are available in each community in British Columbia. The protocols provided in the appendices are samples only and should be used as the basis of a protocol that is tailored to your community's resources and your agency's work.

---

[1]Prevalence rates were 54 per 1000 elderly persons in private dwellings in British Columbia, which result in an estimate of 16,000 abused elderly persons in British Columbia. National Survey on Abuse and Neglect of the Elderly in Canada: The Ryerson Study (1989).

There is a need for each agency in each community to tailor these procedures and protocols to its specific needs. Indeed, it is hoped that the circulation of this document will also lead to the formation of community networks to develop and coordinate responses to elder abuse.

This document contains:

- definitions of elder abuse;
- ethical principles which may help guide community intervention;
- a generic protocol which can be applied to rural or urban communities with a variety of available resources;
- a resource list to assist in establishing an elder abuse network in your community;
- an intake form to help in recording reported incidents of elder abuse (Appendix A);
- sample protocols from a range of service agencies -- Home Support agency, Continuing Care facility, Hospital, Community Law office and Health Unit (Appendix B);
- a table of indicators of abuse and neglect (Appendix C);
- an overview of financial abuse authorities (Appendix D);
- an overview of provincial licensing authorities (Appendix E);
- an overview of the services which various resources may offer (Appendix F);
- a bibliography (Appendix G);
- an audio visual resource list (Appendix H).

PRINCIPLES

The following principles are intended only as guides to help formulate your thoughts on the subject of elder abuse and what can be done to alleviate and prevent it. You may find them useful in developing your own protocol.

1. As with all adults, the elderly have the right to:

   - the basic requirements of life - food, clothing, shelter, and social contact;
   - live their lives as they wish provided they do not infringe upon the rights and safety of others;
   - protection from physical, emotional, financial, sexual and medication abuse; violation of civil/human rights, and neglect;
   - information about their civil and legal rights;
   - participate in making decisions about themselves in accordance with their ability to do so;
   - refuse assistance and intervention;
   - self determination.

2. Every situation involving suspected abuse and neglect must be assessed individually to determine the best interests of the person(s) involved and the degree of intrusion warranted. Situations will vary in degree of risk for the adult person.

3. In a suspected case of abuse, intervention:

   - should be the least intrusive or restrictive;
   - should be aimed at maximizing the elderly person's/family's choices;
   - should be based on the elderly person's/family's strengths and abilities for positive action;

3. Intervention - continued

   - can only be undertaken with the voluntary and informed consent of the elderly person whenever and to whatever degree that person is able to participate;

   - should respect the elderly person's/family's confidentiality.

4. Assault, theft, uttering threats, fraud and neglect are crimes. The police should be called to deal with complaints or instances of alleged criminality.

DEFINITIONS

The following definitions have been adopted by the InterMinistry Committee on Elder Abuse, and are intended to describe acts against elderly persons which are considered abusive. These are not legal definitions; rather, they are intended to help people in the community and professionals working with the elderly to recognize elder abuse, which is a social phenomenon as well as, in some cases, a crime.

The concept of elder abuse is typically used to refer to abuse that occurs to an older person by a family member, a friend, staff in group residential settings, or anyone the older person relies on for basic needs.

Someone who commits elder abuse usually has control or influence over the older person. Victims know and trust their abuser. Most victims of elder abuse depend on the person who hurt them, sometimes for food, shelter, personal care, or companionship.

Harm caused by strangers may be considered a crime but it is not considered to be elder abuse, nor is an older person's self-neglect considered to be elder abuse.

These definitions are suggested for consideration, with the caution that elder abuse is a complex phenomenon which may not be easily defined to the satisfaction of all.

Elder abuse is any action/inaction which jeopardizes the health or well-being of an elderly person. It may include:

Physical Abuse:	Any act(s) of violence or rough treatment causing injury or physical discomfort. May include the use of restraints.
Psychological or Emotional Abuse:	Any act, including confinement, isolation, verbal assault, humiliation, intimidation, infantilization, or any other treatment which may diminish the sense of identity, dignity, and self-worth.
Financial Abuse or Exploitation:	The misuse of an elderly person's funds and assets; obtaining property and funds without that person's knowledge and full consent, or in the case of an elderly person who is not competent, not in that person's best interests.
Sexual Abuse:	Any sexual behaviour directed towards an elderly person without that person's full knowledge and consent; i.e., sexual assault, sexual harassment, or use of pornography.
Medication Abuse:	Misuse of an elderly person's medications and prescriptions, including withholding medication and overmedicating.
Violation of Civil/Human Rights:	Denial of an elderly person's fundamental rights (according to legislation, the Charter of Rights and Freedoms, or the U.N. Declaration of Human Rights); for example: withholding of information; denial of privacy; denial of visitors; restriction of liberty; or mail censorship.
Neglect:	Active Neglect Intentional withholding of basic necessities or care. Passive Neglect Not providing basic necessities and care because of lack of experience, information, or ability.

GENERIC PROTOCOL

(See Appendix B for sample protocols.)

Step #1: INTAKE

- Initial contact should be documented to include: name, address, phone number, age, sex, health status, language spoken, living arrangements of elderly person; name and address of referral source, where possible; details of suspected abuse/abusive situation.
- See Appendix A for sample intake form.
- Consult with supervisor.
- Determine whether case should be referred to another agency or assessed by your agency.

Step #2: ASSESSMENT

- Interview: should take place in the elderly person's home or neutral setting. The elderly person and the alleged abuser should be interviewed separately. In criminal situations, alleged abusers should be interviewed by the police.
- Review indicators of abuse and neglect (see Appendix C).
- * Enable the elderly person to decide or participate in deciding future course of action unless they are clearly not capable of doing so.
- Make collateral checks with others; e.g., physician, social worker, health unit, hospital, church, etc.
- Consult with supervisor.
- Determine whether case should be referred to another agency or action taken by your agency.

*Note: A person of any age who is suffering from great stress or loss will have difficulty remembering information, but this should not be confused with incompetency.

Step #3: ACTION

- Action may include a coordinated response from a variety of services.
- Action may involve repeated interviews, visits, or support.
- The elderly person should be advised of their options, including the option to seek and instruct legal counsel to take action on their behalf.
- * If the elderly person is competent to make decisions and refuses assistance, leave a list of resources available, including an emergency number and terminate the interview.
- If there is evidence of sexual, severe psychological, or physical abuse, you may wish to contact the police and physician.
- If there is evidence of financial abuse, and if there is a question of the elderly person's ability to make decisions, you may wish to contact the Office of the Public Trustee. (see Appendix D)
- If the elderly person accepts assistance, identify and locate appropriate resources.
- Submit completed report to supervisor and contact initial referral source as appropriate.

Step #4: FOLLOW UP

- Follow-up case in manner appropriate to action taken (see above).
- Close case where there does not appear to be a need for further intervention or follow-up.

*Note: Victims of abuse may refuse assistance out of fear that abuse may escalate if the abuser should find out. It is important not to arouse anger in the abuser.

COMMUNITY RESOURCES

As every community has different resources available, you may wish to make a list of contacts within your community.

Emergency Intervention:

e.g., Police
Victim Assistance
Hospital
Transition House
Medical Health Officer
Licensing Officer

_____

_____

_____

Community Support Services:

e.g., Home Support Agency
Senior Citizens' Counsellor
Continuing Care Division
Mental Health Services
Church
Transition House Counsellor
Social Worker
Community Law Office/Legal aid
Seniors' support group
Office of the Public Trustee
Public Health Nurse
Adult Day Care Centre
Friendship Centre
Multicultural Services

_____

_____

_____

PROVINCIAL TELEPHONE NUMBERS

For further information about services and programs available to assist in cases of elder abuse, contact the following:

OFFICE OF THE PUBLIC TRUSTEE (Vancouver)	660-4444
VICTIMS' INFORMATION LINE	1-800-842-8467
LOCAL HEALTH UNIT	see Blue Pages of telephone book
POLICE	see inside cover of telephone book
ALZHEIMER SOCIETY	see local telephone book
SENIOR CITIZEN COUNSELLORS PROGRAM	1-800-663-2656

CONCLUSION

This document is a beginning. We trust that these principles, procedures, and protocols will provide the basic tools for your community to work together in alleviating the complex and serious problem of elder abuse.

If you have any questions, suggestions, or wish to discuss any of the issues raised in this document, please contact:

Elder Abuse Coordinator
Continuing Care Division
Ministry of Health and
Ministry Responsible for Seniors
914 Yates Street
Victoria, British Columbia
V8V 4V7
Telephone: (604) 387-2525

APPENDIX A: INTAKE FORM

Elderly Person:

Name_____ Age_____ Sex_____ Phone_____

Address_____

Physical Status_____

Mental Status_____

Primary Language_____

Type of Abuse_____ Emergency?_____

Relationship/Living Arrangement of Alleged Abuser to Elderly Person

_____

Source of information (where possible):

Name_____ Phone_____

Relationship to elderly person_____

Collateral checks: Health Unit_____

Doctor_____

Other_____

Assessment to be done by_____

Action Plan or Referral_____

_____

_____

APPENDIX A: Continued

Resources available_____

_____

Barriers to Service_____

_____

Outcome_____

Staff_____ Date_____

Supervisor_____ Date_____

APPENDIX B: SAMPLE PROTOCOLS

		Page Number
1.	Home support agency	iv
2.	Continuing care facility	vi
3.	Hospital	xiii
4.	Community information service (legal)	xvi
5.	Health Unit	xix

APPENDIX B: SAMPLE PROTOCOL FOR HOME SUPPORT AGENCY

PROTOCOL # 1

COURTESY OF FERNWOOD HOME SUPPORT SERVICES SOCIETY VICTORIA, BRITISH COLUMBIA

Policy: Any form of client abuse will not be tolerated

Procedure: For the protection and well-being of both clients and staff members, the following shall apply:

1) It is essential that every employee recognize the client's right to dignity and proper care.

2) Abuse includes:

   Acts of commission or deliberate omission by a person or persons on a client that results in the unwarranted physical pain, injury, physical correction or confinement such as being hit, slapped, bruised, sexually molested, cut, burned or physically restrained. Also, debilitating psychological or mental anguish such as being humiliated, treated as a child, frightened, intimidated, threatened or isolated.

3) In the event of a client reacting unfavourably or refusing normal or necessary assistance, patience and understanding will be required.

4) Do not attempt to overcome the resistance unless the client is in immediate danger of physical harm. Never reciprocate aggression.

5) If a situation arises which an employee feels incapable of handling, the employee is instructed to request the assistance of a supervisor immediately.

6) In the absence of supervisory personnel, employees are to call the office and inform other office personnel.

Conditions:

a) Physical and/or verbal actions which would jeopardize the working relationship between the staff member and the client are not acceptable.

b) Employees engaged in any form of abuse, including shouting, or use of profanity, will be subject to disciplinary action up to and including dismissal.

c) Any employee who witnesses or becomes aware of an incident of client abuse shall report it immediately to the immediate supervisor. Failure to do so shall be cause for disciplinary action.

APPENDIX B: SAMPLE PROTOCOL FOR A CONTINUING CARE FACILITY

PROTOCOL # 2

COURTESY OF NEW VISTA SOCIETY BURNABY, BRITISH COLUMBIA

Policy: No form of resident/tenant mistreatment will be tolerated by staff, visitors, volunteers or residents/tenants.

A. CARE HOME

Purpose: To ensure a safe and trusting atmosphere is maintained in the New Vista Care Home where both the residents and the staff may live and work without the fear of mistreatment.

Any incident of suspected or actual mistreatment will be reported to administration as soon as possible and a thorough and confidential investigation conducted by them. Anyone who mistreats a resident may be prosecuted under law.

APPLICATION:

For the protection and well-being of residents the following shall apply:

1) It is essential that every employee recognize the resident's right to dignity and to a caring environment.

2) In the event of a resident reacting unfavourably or refusing normal or necessary assistance, patience and understanding will be required.

3) Unless the resident is in immediate danger of physical harm,there will be no attempt to overcome physical resistance. Resistance is never reciprocated with aggression.

4) If attacked, staff may respond in self-defence with the least forceful method to remove themselves from the situation.

Application: (continued)

5) If a situation arises which an employee feels incapable of handling, the employee is instructed to immediately request the assistance of a supervisor.

6) In the absence of supervisory personnel, employees are directed to contact the nurse in charge.

7) An incident report shall be completed when such a situation arises.

Mistreatment includes:

1)	Physical Abuse:	Infliction of bodily injury by one or more instances of striking, shoving, slapping, pinching, choking, kicking. Includes the use of restraints not in keeping with Policy and Procedures.
2)	Psychological/ Emotional Abuse:	Infliction of emotional injury by one or more instances of yelling, scaring, threatening. May include use of silence, isolation or improper use of restraints.
3)	Financial Abuse/ Exploitation:	The misuse of the resident's funds and assets, obtaining client's property and funds without the resident's knowledge and full consent.
4)	Sexual Abuse/ Assault:	Any form of sexual contact without the resident's consent.
5)	Medication Abuse:	Non-compliance with the Policies and Procedures relating to safe medication administration and restraint practices.

Application: (continued)

6) Violation of Rights: Denial of rights that are assured under the Charter of Rights and that do not impinge on the rights and safety of others.

7) Neglect:

(a) Active Neglect
Wilful withholding of basic necessities and care.

(b) Passive Neglect
Withholding of basic necessities and care.

(c) Self-neglect
Not providing oneself with basic necessities of care.

Reporting and Investigation:

1) Any employee who has been mistreated by a resident will immediately report the incident to the Nurse in charge. An incident report will be completed and given to the Department Director.

2) Any employee who has witnessed mistreatment of a resident or suspects there has been abuse of a resident will report the incident or suspicion immediately to their supervisor. An incident report will be completed and given to the Department Director.

Exception - When no direct supervisor is on duty, the incident should be reported to the Nurse in charge, i.e., weekends, evenings.

3) Failure to report an incident or suspicion of mistreatment shall be cause for disciplinary action.

Reporting and Investigating: (continued)

4) The supervisor will immediately, if possible, and in any event within 24 hours of the incident occurring, give the incident report to the Department Director, including initial investigation information.

5) Upon receipt of the incident report the Department Director will notify the Administrator and will institute a thorough investigation, which will include interviews with all parties involved and immediately notify the Administrator and report in writing.

6) A written report of the investigation will be submitted to the Administrator and will state whether or not there was a suggestion of elder mistreatment.

7) When the initial investigation suggests there may be elder mistreatment, the following shall apply if the suspected abuser is:

   (a) an employee, that employee shall be immediately suspended without pay;

   (b) a volunteer, that volunteer will be required to stay away from the facility;

   (c) a visitor, that visitor will have visiting times restricted to allow full supervision during visits;

   (d) a resident, that resident will be restricted from visiting the alleged victim.

8) Depending upon the nature of the alleged elder mistreatment, the Administrator may notify the RCMP of the results of the initial investigation. If the RCMP is to be notified, the suspected abuser shall not be informed of the nature of the alleged abuse until interviewed by the RCMP.

9) The medical Health Officer shall be notified by the copy of the incident report plus a phone call when the RCMP are notified.

Reporting and Investigation: (continued)

10) A complete investigation shall be done by the Administrator either internally or in conjunction with the Ministry of Health and Ministry Responsible for Seniors and/or the RCMP.

11) If there are no findings of elder mistreatment, the following shall happen if the suspected abuse is:

(a) an employee, that employee shall be reinstated with full back pay and a letter shall be put on the file stating there was no evidence of elder mistreatment;

(b) a volunteer, the volunteer may resume previous position;

(c) a visitor, that visitor will be allowed to visit freely;

(d) a resident, that resident will be allowed to visit freely.

12) If there are findings of elder mistreatment, the following shall happen if the abuser is:

(a) an employee, further action including disciplinary measures shall be taken as deemed appropriate by the employer and as per the collective agreement. Charges may be laid;

(b) a volunteer, that volunteer shall be refused further entry to the facility. Charges may be laid;

(c) a visitor, that visitor shall be refused further entry to the facility. Charges may be laid;

(d) a resident, a case conference will be held and the Continuing Care Division will be notified.

B. RESIDENTIAL PROPERTIES

Purpose: To ensure a safe, trusting environment is maintained for each tenant of the New Vista Properties.

Application:

1) All witnessed, or suspected, incidents of tenant mistreatment will immediately be reported to the Director of Residential Properties.

2) Failure to report an incident or suspicion of mistreatment shall be cause for disciplinary action.

3) If an employee is involved:

   (a) The Director of Residential Properties will notify the Administrator and will institute an investigation.

   (b) A written report of the investigation will be submitted to the Administrator and will state whether or not there was a suggestion of elder mistreatment.

   (c) When the initial investigation suggests there may be elder mistreatment by an employee, that employee shall be immediately suspended without pay.

   (d) Depending upon the nature of the alleged elder mistreatment, the Administrator may notify the RCMP of the results of the initial investigation. If the RCMP is to be notified, the suspected abuser shall not be informed of the nature of the alleged abuse until interviewed by the RCMP.

   (e) A complete investigation shall be done by the Administrator, either internally or in conjunction with the RCMP.

   (f) If there are no findings of elder mistreatment, the employee shall be reinstated with full back pay and a letter shall be put in the file stating there was no evidence of elder mistreatment.

Application: (continued)

(g) If there are findings of elder mistreatment, further action, including disciplinary measures shall be taken as deemed appropriate by the employer and as per the collective agreement. Charges may be laid.

4) If persons, other than employees, are involved:

(a) The Director of Residential Properties will refer the case to the appropriate community agency and submit a written report to the Administrator.

(b) The Director of Residential Properties will monitor the situation to ensure the safety and well-being of the tenant.

Compliance:

100%

Evaluation:

Observation
Incident Reports

Reference:

Restraint Policies
Medication Policies
Visitor Policy

APPENDIX B: SAMPLE PROTOCOL FOR A HOSPITAL

PROTOCOL # 3

COURTESY OF THE DEPARTMENT OF SOCIAL WORK, GREATER VICTORIA HOSPITAL SOCIETY

I. Criteria for Social Work Involvement: Patient is 65 years and older, and definitely diagnosed as being abused physically, sexually, emotionally or financially; a suspected case of elder abuse, or has unexplained physical symptoms.

II. Social Work Intervention

A. Emergency Measures (Recorded)
Crisis intervention.

B. Assessment

1. Process (Not recorded)

a. review referral, chart, and any other pertinent, written information;
b. consult with staff involved;
c. interview patient alone;
d. interview caregiver or other significant person (with patient's permission) alone.

2. Information (To be recorded)

a. From patient:

i. Demographic data.
ii. Living conditions, income, ability to do self care, typical day, outside contact, tasks done by others, degree of support given by caregiver, directly quote whether patient has ever been hit, had food or meds withheld, been oversedated, had money or property removed from them, or fears being left with caregiver.
iii. Patient's view of the problems and possible resolution.
iv. Corroborative evidence to establish patient's mental functioning, e.g., Goldfarb Dementia Scale.
v. Patient's motivation and consent to explore situation further with relatives/collateral sources/others involved.

b. From caregiver:

i. Demographic data and reason person involved in patient's care.
ii. Typical day, caregiver's perception of patient; expectations of patient and degree of support given, other resources used.
iii. Caregiver's knowledge of patient's health and care needs.
iv. Explore difficulties caregiver encounters, and their response.
v. Caregiver's knowledge of alternative resources available.
vi. Caregiver's view of the problems and possible resolution.

c. From Social Worker:

i. Social worker's impression of patient and caregiver, and the implications for discharge planning.

C. Plan (To be recorded)

1. Identify problems to be addressed, and refer as appropriate to:

a. Liaison Nurse/community assessor for Continuing Care Division assessment for placement or home supports to relieve home situation.
b. Transition House for immediate shelter out of patient's home (women only).
c. Police re: laying charges.
d. Lawyer/Law Centre for advice.
e. Geriatric short stay assessment units at Fairfield Health Centre or Royal Jubilee Hospital for a full multidisciplinary assessment.
f. Counselling - patient and/or family or caregiver by social worker.
g. Next-of-kin (especially if out of town).
h. Government agencies re: finances, e.g., Public Trustee.
i. Health care team for consultation.
j. Geriatric Psychiatrist for competency assessment/treatment.

2. Outline Plan in care plan on Chart.

3. Follow case until problems resolved and/or discharge plan agreed upon by patient, caregiver and health team. Or patient dies or terminates social work intervention.

C. Plan (continued)

4. Contact patient by phone within one week of discharge and review situation.

5. Contact professional who will follow situation in community, e.g., Continuing Care Division Assessor, MD, Home Care Nurse.

D. Implementation Process (Not recorded)

E. Outcome (To be recorded)

1. Indicate whether each plan under "C" was achieved. If not, why not.

III. Criteria for Terminating Social Work Intervention (To be recorded)

1. Goals achieved.

2. Patient refuses social work intervention.

3. Patient dies.

APPENDIX B: SAMPLE PROTOCOL FOR A COMMUNITY LEGAL OFFICE

PROTOCOL # 4

COURTESY OF NORTH SHORE COMMUNITY SERVICES

General policy guidelines:

The right of self-determination is paramount.

A person is competent and capable unless legally declared incompetent or certified incapable.

Instructions regarding individuals and their affairs are to be taken from the elderly person themself, rather than from a family member or other person purporting to be acting for the elderly person.

Assessment/Case Identification:

Often an initial report of abuse is clouded by justification (i.e., caregiver's stress) and/or the victim's denial or apparent reluctance to acknowledge the situation.

The purpose of the assessment stage is to focus on the act itself. Is there reason to suspect abuse exists? What is the nature of the abuse? What has happened? What behaviour can be documented? What have been the consequences?

The reasons for the abuse, value judgement, ability or options for change - all of these belong to the next stage: case management.

First tell a caller (client): "I am not a lawyer. I am a legal information counsellor. Everything we talk about today is confidential. I will not share this information with others unless you ask me to or give permission. There is no charge for our service."

Assessment/Case Identification: (continued)

1. Procedure for Self-Reports

If the report comes from the victim of the abuse or from the abuser: Establish what has happened and then take direction from the client as to further staff involvement. Document the information obtained from your interview in a case file. If appropriate, proceed to case management stage of protocol.

If the client is a person who appears confused, inconsistent in giving instruction, and/or displays difficulty in understanding information offered: Determine whether there is an immediate danger or need for intervention, and discuss case with supervisor or supervising lawyer.

If the client lives with the abuser: Offer flexibility in terms of telephone conversations, location of interview, etc. Assure the client that if you need to call back to the home and someone else answers, you'll identify yourself as the "volunteer centre" or whatever else is appropriate and non-threatening.

If the client is disabled (physically, mentally, in terms of language), acknowledge the special difficulties involved in giving information. Offer flexible arrangements. Communicate that extra time or unusual effort is part of the service we are funded to provide.

If the client is requesting service that is not possible or appropriate for you to provide, given your agency's mandate, identify the appropriate body to whom the caller can be referred. Explain the other agency's service to the person and ask if they wish you to call the other service. If they do, contact the appropriate agency or person, and note a date to follow up the referral.

If the elderly person is not ready to use a service, leave written information with that person as to where and how services may be obtained when they are ready to access them. Leave your agency information with the person so that they may contact you again.

2. Procedure for Reports from Another Party

If the client is a staff person of another service, a neighbour, friend or relative (someone other than the person subject to abuse or the abuser), share our philosophy of self-determination of the elderly. Tell the caller that we do not have a mandate to investigate or intervene. Explain that we act on the instructions of the elderly person, and that our procedures reflect our philosophy which is to return power and control to victims. Explain that we prefer a victim of abuse be told about our service and given the option to contact us directly.

2. Procedure for Reports from Another Party (continued)

Do not enter into a case discussion if to do so would be to violate client confidentiality.

If the caller is seeking information or guidance on the best way to support or assist an abused person, or the abuser, offer that information unless your actions will trespass on the elderly person's rights of privacy and self-determination.

Offer "entry role", i.e., check to be sure that the elderly person is receiving all entitlements, or provide information about low-cost housing. Often the person reporting abuse will become a valuable ally and support to an elderly person subject to an abusive situation.

Complete case record sheet, identifying the name of the senior (if available) and the name of the actual caller. If appropriate, proceed to case management stage of protocol.

Case Management:

This stage involves identifying the range of options available to the client and taking instruction from the client.

Refer to Eligibility Criteria before proceeding.

A community law office differs in many ways from other services that might come into contact with the elderly. We do not have to make decisions in the best interests of the client's health, family relationships, or even the protection of their assets. It is our role to ensure that our client has:

a) access to accurate information;
b) the right to self-determination (to decide to make changes, to stay in an abusive situation, or to exercise self-neglect);
c) appropriate help and advocacy.

If the client is a person who has been subject to abuse: Is that person capable? Assume capability unless the client has been certified as incapable or is subject to a Supreme Court Order of Committeeship.

If the client has been declared incapable or is under the care of a committee, exercise discretion in determining whether or not to take instruction. The client may be entitled to representation to ensure basic civil liberties. Discuss with supervisor or supervising lawyer.

Instruction is to be taken only from the elderly person and not from another representative unless proof of extent of authority is available, documented, and copied for the file.

APPENDIX B: SAMPLE PROTOCOL FOR HEALTH UNIT

PROTOCOL # 5

COURTESY OF VANCOUVER HEALTH DEPARTMENT

Procedures:

A. INTAKE:

Any staff person who is made aware of a possible situation of abuse of an elderly person will document the situation in writing. This documentation should include the following:

- name, address, phone number, age, sex, health status and living arrangements of the elderly person;
- name, address, phone number, and relationship of referral source;
- an indication as to whether the situation is urgent;
- description of suspected abuse including when the abuse took place.

Also, the following questions are suggested and answers should be documented:

- who is the alleged abuser, and do they live with the elderly person?
- is the elderly person known to the Vancouver Health Department?
- does the elderly person know of this referral? Did that person request help?
- is the elderly person competent to make a decision?
- what other resources have been tried?
- does the person being referred speak or understand English? If not, note language of choice.

B. PRELIMINARY ASSESSMENT:

1. If person resides in a licensed Community Care Facility, contact the Director of C.C.F. Licensing for further assessment and follow-up.

B. PRELIMINARY ASSESSMENT: (continued)

2. If person resides in the community and is known to the Health Department:

   a. Contact primary worker by telephone, and forward intake documentation.
   b. Primary worker checks client's file for risk factors (history of abuse, mental status, caregiver stress or deviance, drug/alcohol abuse, history of mental illness, etc.).
   c. Primary worker obtains collateral information as appropriate; for example, contacts client's physician, referral source, service providers, etc.
   d. Primary worker discusses intervention with supervisor, and if appropriate, MHO at Health Unit.

3. If person being referred is not known to the Health Department:

   a. If the elderly person meets eligibility criteria for Health Department programs, follow procedures listed below under Assessment.

   b. If the elderly person is not eligible for Health Department programs, complete written documentation and submit to supervisor. The decision is then made whether to continue with assessment or, in consultation with MHO, and Unit Director (or Clinics Administrator), the decision is made that the situation does not fall within the Vancouver Health Department mandate, and

      i) referral is made to another appropriate resource (i.e. police, Office of the Public Trustee, community resource),
      ii) a bring forward is set up for future follow-up, if deemed appropriate.

C. ASSESSMENT:

Staff member conducts personal assessment to determine if abuse situation exists:

1. Make appointment for initial home visit or arrange to meet client in a neutral setting., e.g., daycare centre, health unit or doctor's office, etc.;

2. Interview client and caregiver separately and then together if appropriate, to assess for physical, emotional or financial abuse. If competency of the client is in question, the primary worker must decide whether or not to involve the MHO for competency testing;

C. ASSESSMENT: (continued)

3. If the primary worker is unable to complete the assessment visit because entry is denied by someone other than the client, return to Health Unit and discuss alternative plans with supervisor and MHO;

4. Based on the information available (client's record, referral information, collateral information and primary worker's observations) a decision is made by the supervisor as to the severity of the client's situation (i.e., what is the level of threat to the physical/mental health of the abuse/neglected elderly person as a result of the situation presented?). If it appears that the elderly person is being abused and remains at risk the primary worker will involve the MHO, client's physician, Office of the Public Trustee and/or the police as appropriate.

D. ACTION:

1. Suspected Abuse Unconfirmed

a. Review the resources available for client and/or caregiver, date that you will keep in touch by visiting or phoning back, and terminate the interview;

b. If the primary worker determines that the client continues to be at risk, follow-up is required;

c. Complete documentation in report form and submit to supervisor;

d. Provide feedback to referral source, as appropriate.

2. Abuse Confirmed

a. If client and/or caregiver refuses assistance and MHO has assessed the client and found the client incompetent to make an appropriate decision, then the MHO, in consultation with the client's physician or physician from the Mental Health Team, will certify the client incompetent under the Mental Health Act and arrange for committal to a hospital psychiatric unit or mental health facility for physical assessment, treatment and follow-up.

When physical abuse is evident and the elderly person is incompetent and at risk, the police have the authority to intervene and remove the abused to a hospital for treatment. Should this happen, contact the Office of the Public Trustee to ensure protection of the client's property;

D. ACTION: (continued)

b. If client is competent to make decisions and refuses assistance, leave a list of resources available, including an emergency number, and terminate the interview;

c. If client/caregiver accepts assistance - identify and facilitate the use of appropriate resources. Resources may include those provided by the Department and/or those provided in the community;

d. If there is evidence of physical abuse, the primary worker is advised to call the police (911) and report it;

e. Complete written documentation in report form and submit to supervisor;

f. Provide feedback to referral source as appropriate.

APPENDIX C: COMMON INDICATORS OF ABUSE AND NEGLECT

Category of Abuse	Indicators
Physical Abuse:	• unexplained injuries such as bruises, burns, swellings • injury for which explanation does not fit evidence • delay in seeking treatment • injury to scalp, evidence of hair pulling • symmetrical grip marks, evidence of shaking
Psychological or Emotional Abuse:	• fear • withdrawal • low self esteem • extreme passivity • elderly person appears nervous around the caregiver
Financial Abuse or Exploitation:	• unexplained discrepancy between known income and standard of living • an elderly person has signed a document (e.g., will, property deed) without full understanding • possessions disappearing • if you work in a financial institution: an elderly person is surprised by an over-drawn or lower-than-expected bank balance; unusual transactions conducted on behalf of an older person.
Sexual Abuse:	• pain, bruises, bleeding in genital area
Medication Abuse:	• reduced mental or physical activity • depression • reduced/absent therapeutic response
Denial of Civil/ Human Rights:	• difficulty visiting, calling, or otherwise contacting an elderly person • elderly person makes excuses for social isolation
Neglect:	• malnourished, dehydrated • missing dentures, glasses, hearing aid • unattended for long periods or tied to bed/chair • unkempt appearance - dirty or inappropriate clothing • untreated medical problems

APPENDIX D: FINANCIAL ABUSE AUTHORITY

1. OFFICE OF THE PUBLIC TRUSTEE:

The Office of the Public Trustee is a provincial government agency which looks after the affairs of people who can no longer manage on their own. The Office of the Public Trustee only acts when there is no other person able or willing to assist the adult. There are a number of ways in which the Public Trustee can assist in situations when vulnerable people are the victims of financial abuse. The authority of the Public Trustee is different, depending on whether the alleged victim is considered to be mentally capable or mentally incapable.

2. POWER OF ATTORNEY:

A Power of Attorney is a legal document, granted by a capable person, which has the effect of giving authority to any person to make decisions for them. A person who is incapable does not have the legal power to grant a Power of Attorney.

Only legal and financial authority can be given to another person in a Power of Attorney. Under current law, power to make health care decisions on behalf of another individual cannot be granted by a Power of Attorney. The person who grants the Power of Attorney can, in the document, give directions to or restrict the power of the person who is given the authority to make decisions.

The Public Trustee can assist in the management of financial and legal affairs when appointed under a Power of Attorney by a person who is legally capable, but needs assistance. The Public Trustee can also investigate the alleged abuse of a Power of Attorney when the person who granted it appears to be mentally incapable.

If the authority is to endure or remain effective, when the person becomes mentally incapable, the Power of Attorney document must have a special enduring clause; otherwise, it ceases to be effective when the person becomes incapable.

3. TRUSTEE OF GOVERNMENT PENSIONS:

A Trustee of Canadian Government Pension Income is a person appointed to receive and spend federal pension income (OAS, GIS, CPP) for the benefit of an incapable pensioner. Any person, including the Public Trustee, can become a Trustee of Government Pension Income by completing an application form and obtaining the required medical doctor's certificate verifying that the person is incapable of handling these funds. These are presented to the nearest Health and Welfare Canada Income Security Program Office.

4. COMMITTEE:

A Committee is a person appointed by court order to make decisions for a person who has been declared, by court order, to be mentally incapable. A Committee could be a private individual (known as a "Private Committee") like a spouse, child or friend. The Public Trustee has the authority to monitor a Private Committee, to investigate and request an accounting. When there is no one able or willing to be appointed as a Private Committee, the Public Trustee may be appointed. The Public Trustee can also become the Committee of the Estate through a certificate of incapability, issued by a Director of a Provincial Mental Health facility or by an officer of a Psychiatric Unit. When the Public Trustee is appointed under a certificate, a court order is not required.

APPENDIX E: LICENSING AUTHORITIES

A. Community Care Facility Act

Many residential care facilities are licensed under the Community Care Facility Act, for example, personal and intermediate care homes and mental health boarding homes. Under the authority of the Act, Section 9 (b), the Medical Health Officer investigates complaints that a facility does not fully comply with the Act or the Adult Care Regulations established under the authority of the Act. The Medical Health Officer must report the results of the investigation to the Provincial Adult Care Facilities Licensing Board.

Information on protocols for the investigation of abuse or neglect in adult care facilities licensed under the Community Care Facility Act may be obtained from the Medical Health Officer or the Licensing Officer in the local Health Unit.

B. Hospital Act, Part 2

Private hospitals are licensed under the Hospital Act, Part 2. Under the authority of the Act, Part 2, Section 19, the Inspector of Private Hospitals investigates complaints or allegations of abuse or mistreatment in licensed private hospitals.

The Inspector of Private Hospitals may be contacted at:

Inspector of Private Hospitals
Continuing Care Division
Ministry of Health and
Ministry Responsible for Seniors
914 Yates Street
Victoria, British Columbia
V8V 4V7
Telephone: 387-2525
FAX: 387-2548

APPENDIX F: RESOURCES

COURTESY OF THE SOCIAL PLANNING AND RESEARCH COUNCIL OF BRITISH COLUMBIA

Service	*How it helps*
Homemaker Home nursing Friendly visitor	Reduces Isolation and gives practical help
Adult day care Respite care	Provides relief for caregiver
Senior Centre activities Transportation aid, e.g., Handy-dart	Gets elder out of home Reduces isolation Provides social contacts
Family Counselling services Specialized employment or drug counselling	Improves relationship Assists abuser to get own life together
Meal programs (in home or out)	Improves nutrition Provides social opportunities
Facility care	A safe and stimulating environment when unable to manage with home support services
Caregiver support group	Helps caregiver to cope
Police	Asserts seriousness of assault, rights of elders Can lay charges Assist in eviction
Legal Aid or Community Law Office	Legal advice/advocacy
Occupational Therapist	Increases independence by home adaptation or patient aids
Physiotherapist	Independence Improves mobility

APPENDIX G:

MINISTRY OF HEALTH AND MINISTRY RESPONSIBLE FOR SENIORS LIBRARY

1515 Blanshard Street
Victoria, British Columbia
V8W 3C8
Telephone: 387-2336

ELDER ABUSE BIBLIOGRAPHY

* BATTERED ELDER SYNDROME: AN EXPLORATORY STUDY
Block, Marilyn R., and Jan D. Sinnott
University of Maryland Centre on Aging,
College Park, Maryland, 1979 WT 30 B651 1979 133 P

* ELDER ABUSE AND NEGLECT: CAUSES, DIAGNOSIS, AND INTERVENTION STRATEGIES
Quinn, Mary Joy, and Susan K. Tomita
Springer Publishing Company, New York, 1986 WT 30 Q7 1986 322 P

* ELDER ABUSE AND NEGLECT: A GUIDE FOR PRACTITIONERS AND POLICY MAKERS
Villmoare, Edwin, and James Bergman, EDS
National Paralegal Institute, San Fransisco
Office of Elderly Affairs, Oregon, 1981 WT 30 V715 1981 181 P

* ELDER ABUSE INFORMATION KIT
Canada Health and Welfare Canada
National Clearinghouse on Family Violence, 1985 WT 30 C212 1985 VP

* PROTECTION OF THE ELDERLY: A STUDY OF ELDER ABUSE
Shell, Donna J.
Manitoba Council on Aging, Winnipeg, 1982 WT 30 S544 1982 60 P

* VICTIMIZATION AND FEAR OF CRIME AMONG THE ELDERLY
Brillon, Yves
Butterworths, Toronto, 1987 WT 30 B857 1987 119 P

* ELDER ABUSE IN NOVA SCOTIA
Filbee, Sara
Dalhousie Law School. 1981 WT 30 F479 1981 41 P

* DUTY BOUND: ELDER ABUSE AND FAMILY CARE
Steinmetz, Susan K.
Sage Publications, Newbury Park, 1988 Volume 166

* ABUSE OF THE ELDERLY: ISSUES AND ANNOTATED BIBLIOGRAPHY
Schlesinger, Benjamin and Rachel
University of Toronto Press, 1988

* HELPING ELDERLY VICTIMS: THE REALITY OF ELDER ABUSE
Wolf, Rosalie S., and Pillemar, Karl
Columbia University Press, New York, 1989

* THE NURSING CLINICS OF NORTH AMERICA
Volume 24/Number 3, September, 1989
Gessner, Barbara A., Armstrong, Myrna L.,
and Rempusheski, Veronica
W.B. Saunders Company, Philadelphia

* COMPREHENSIVE INDEX OF ELDER ABUSE
Sengstock-Hwalek
Social Program Evaluators and Consultants Inc.
Michigan, 1985 WT 30 S476 1986

* COMPREHENSIVE INDEX OF ELDER ABUSE:
INSTRUCTION MANUAL
Sengstock-Hwalek
Social Program Evaluators and Consultants Inc.
Michigan, 1985

* NATIONAL CONFERENCE ON ELDER ABUSE
AND CRIME, 1ST, TORONTO, JAN. 23-25, 1991.
Ryerson School of Nursing
Audio Archives of Canada
Richmond Hill, Ontario, 1991 17 Audiocassettes WT 30 R993 1991

* RESIDENT ABUSE IN NURSING HOMES:
RESOLVING PHYSICAL ABUSE COMPLAINTS
United States, Department of Health and
Human Services
Office of Inspector General, U.S. Govt. Printing Office
Washington, D.C., 1990 WT 30 U58 1990 29 P

* A LEGAL HANDBOOK FOR THE HELPING PROFESSIONAL
Editors: D. Turner and M. Uhlemann
The Law Foundation of British Columbia
Victoria, British Columbia, 1991

* ACTION ON ELDER ABUSE: CURRENT ACTIVITIES IN BRITISH COLUMBIA FOCUS ON VICTORIA OPTIONS
Mental Health Services and SPARC (Social Planning and Research Council)
Ministry of Health and Ministry Responsible for Seniors
Victoria, British Columbia — WT 30 B862A 1990

* ELDER ABUSE AND NEGLECT IN CANADA
McDonald, P. Lynn
Butterworths, Vancouver, British Columbia — WT 30 M135 1991

* GUIDELINES FOR ESTABLISHING STANDARDS FOR: HEALTH CARE RELATED TO ABUSE, ASSAULT, NEGLECT AND FAMILY VIOLENCE.
Report of the SubCommittee on Institutional Program Guidelines
Health and Welfare Canada — HQ 809 C212 1989

* GERONTOLOGY
Rempusheski, Veronica
W.B. Saunders Company, Philadelphia — WY 100 N974 V24:3 1989

* FAMILY VIOLENCE: PERSPECTIVES ON TREATMENT, RESEARCH AND POLICY
Roesch, Ron
British Columbia Institute on Family Violence — HQ 809 R718 1990

* SOUTH VANCOUVER ISLAND CONFERENCE ON ABUSE AND NEGLECT OF THE ELDERLY: ASSESSMENT AND INTERVENTION
Mental Health Services and Tomita, Susan
Ministry of Health and Ministry Responsible for Seniors
Victoria, British Columbia — WT 30 B862B 1990

* RESIDENT ABUSE IN NURSING HOMES: UNDERSTANDING AND PREVENTING ABUSE
U.S. Department of Health and Social Services
U.S. Government Printing Office — WT 30 U58A 1990

APPENDIX G:

ELDER ABUSE
AUDIO VISUAL RESOURCE LIST

Title: A HOUSE DIVIDED, 1988 — Source: National Film Board
Format: VHS — #100 - 1045 Howe Street
Length: 35 minutes — Vancouver, B.C. V6Z 2B1

Evaluation: Documentary with four short stories of elder abuse. Shows possible resolutions. American production.

Title: THE GOLDEN YEARS, 1988 — Source: Ministry of Health and Ministry
Format: VHS — Responsible for Seniors Library
Length: 60 minutes
Evaluation: Very graphic description of physical abuse; how the system works/doesn't work. Excellent training film or for stimulating discussion. PBS Documentary.

Title: MR. NOBODY, 1987 — Source: National Film Board
Format: VHS — #100 - 1045 Howe Street
Length: 35 minutes — Vancouver, B.C. V6Z 2B1
Evaluation: Canadian documentary about self-neglect. Shows how the helping system can be abusive (i.e., articles are stolen from the house during the clean-up).

Title: SILENCE UPSTAIRS, 1985 — Source: National Film Board
Format: 16 mm — #100 - 1045 Howe Street
Length: 13 minutes — Vancouver, B.C. V6Z 2B1
Evaluation: Very realistic account of caregiver's stress, but does not offer alternatives or suggestions.

Title: INCIDENT REPORT, 1984 — Source: Mental Health Resource Library
Format: VHS — Ministry of Health and Ministry
Length: 24 minutes — Responsible for Seniors Library
Evaluation: Realistic scenario of how abuse can happen in a facility. Provides a basis for questions and is accompanied by a training manual.

Title: READY OR NOT HERE I COME, 1985
Format: VHS
Length: 52 minutes

Source: VEC Criterion Video
75 Horner Avenue, Unit 1
Toronto, ON M8Z 4X5
(416) 252-5907
(Inter-library loans)

Evaluation: Production well done. First half describes cases of abuse. The second half is a discussion regarding prevention, awareness, education and caregivers.

Title: STOP THE SILENCE, 1990
Format: VHS
Length: 24 minutes

Source: SPARC of B.C.
#106 - 2182 W. 12 Avenue
Vancouver, B.C. V6K 2N4
(604) 736-8118
Cost: $25

Evaluation: Excellent basic tool for public education and awareness. Developed for British Columbia audience, outlining generic resources.

Title: ELDER ABUSE AND NEGLECT IN THE FAMILY - THE HIDDEN SORROW: AN OVERVIEW, 1986
Format: VHS
Length: 24 minutes

Source: National Victims Resource Centre
Department of Solicitor General
Ottawa, Ontario K1A 0P8
1-800-267-0454

Evaluation: Excellent overview for training session.

Title: ELDER ABUSE AND NEGLECT IN THE FAMILY - DIFFICULT CHOICES: ETHICAL ISSUES IN CASEWORK, 1987
Format: VHS
Length: 21 minutes

Source: National Committee for Prevention of Elder Abuse
The Medical Centre of Central Massachusetts
119 Belmont Street
Worcester, MA 01605

Evaluation: Studying one case, caseworkers, lawyers, and other professionals analyze the rights of individuals and examine the issues of competency and quality of life.

Title: ELDER ABUSE AND NEGLECT IN THE FAMILY - IN PURSUIT OF A LIFE WITHOUT VIOLENCE: INTERVENTION STRATEGIES, 1987

Source: Ministry of Health and Ministry Responsible for Seniors Library

Format: VHS

Length: 26 minutes

Evaluation: Using four actual cases of elder abuse, social workers discuss intervention strategies which involve conducting an assessment, developing a service plan, coordinating community services, using the legal system, and building trusting relationships.

Title: ELDER ABUSE: EVERYONE'S CONCERN, 1984

Source: Montana Dept. of Social and Rehabilitation Services
Program Officer II
P.O. Box 4210
Helena, Montana 59604
(406) 444-3865

Format: VHS

Length: 30 minutes

Evaluation: Public awareness regarding unintentional elder abuse from its origins to response from social service agency.

Title: STANDING UP FOR YOURSELF: HOW TO RECOGNIZE AND AVOID FINANCIAL ABUSE, 1991

Source: Province of Manitoba
Seniors Directorate
Toll Free: 1-800-665-6565

Format: VHS

Length: 13 minutes

Evaluation: This video offers valuable information to seniors on avoiding financial abuse and on getting help, if needed.